SECTION 2

PHYSICIAN SERVICES

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1 GENERAL POLICY

A. Physician Services

The physician services program provides a scope of service to meet the basic medical needs of eligible categorically and medically needy individuals. The program is based on the art and science of caring for those who are ill through the practice of medicine or osteopathy by a practitioner who (1) meets all requirements necessary to participate in the Utah Medicaid program, (2) who agrees to abide by Department rules to render medically necessary physician services in accordance with a specific, signed provider agreement, and (3) who accepts Utah Medicaid reimbursement as payment in full. A Medicaid patient cannot be billed for services provided, except under the conditions stated in SECTION 1 of this manual, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients. Physicians in other states can provide services to Utah Medicaid clients providing they are licensed, meet the requirements of participation in the Medicaid program in their state of residence, and become enrolled providers in the Utah Medicaid program.

Physicians may participate in a private practice, with a Health Maintenance Organization (HMO) that has a contract with the Department, a federally qualified Health Center (FQHC), or other organized entity recognized by the Department for providing physician services. With the cooperation and advice of the Utah Medical Care Advisory Committee, the Department has established standards and regulations governing care for which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for reasonable and necessary medical services and supplies subject to the exclusions and limitations set forth in policy and rules.

Physician services are a mandatory Medicaid, Title XIX program authorized by Sections 1901 and 1905(a)(1) of the Social Security Act, 42 CFR 440.50, and Sections 26-1-5 and 26-18-3, Utah Code Annotated.

B. Physician Assistant Services

An individual who has met the requirements of federal regulation and state law is authorized to participate in the Medicaid program serving patients in cooperation with a supervising provider. The working relationship between physician and physician assistant allows the physician and physician assistant to determine the appropriate amount of supervision and how that supervision will be documented. Under the practice rules, the following applies:

1) The supervising physician shall provide supervision to the physician assistant to adequately serve the health care needs of patients and ensure that the patient's health, safety and welfare will not be adversely compromised.

2) A Delegation of Services Agreement, maintained at the site of practice, shall outline specific parameters for review that are appropriate for the working relationship.

3) There shall be a method of immediate consultation by electronic means whenever the supervising physician is not present and immediately available.

4) The supervising physician shall review and co-sign sufficient numbers of patient charts and medical records to ensure that the patient's health, safety, and welfare are not adversely compromised.

A physician assistant can provide services consistent with the practice of the physician with whom he works. If the physician is a primary care provider, then by definition the physician assistant working with that physician would be providing primary care services. Often, the physician assistant is the first person to evaluate a patient presenting for service at the physician's office. Under the statute, the physician assistant works under the supervision of a physician, is not an independent practitioner, and cannot bill independently.

Physician assistant services will be subject to applicable limitations and exclusions set forth in Medicaid policy. The physician assistant must have a committed and documented practice relationship under the supervision of a physician. Physician assistants working as employed staff in clinics or other facilities do not qualify to have their services separately billed. Refer to Chapter 1 - 7, Physician Assistant Services: Limitations, for limitations on applicable physician assistant services.

1 - 1 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed care plan, such as a health maintenance organization (HMO) or Prepaid Mental Health Plan (PMHP), must receive all health care services through that plan. Refer to SECTION 1 of this manual, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan. For more information about managed health care plans, please refer to SECTION 1, Chapter 4, MANAGED CARE PLANS. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in this section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of HMOs and PMHPs with which Medicaid has a contract to provide health care services is included as an attachment to this provider manual. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to which plan the patient must use is available to providers, a fee-for-service claim will not be paid even when information is given in error by Medicaid staff.

Mental Health Services and Prepaid Mental Health Plan

If you think an individual may qualify for Medicaid, you should contact the appropriate PMHP to obtain authorization for mental health services. Even if the individual is not yet enrolled with a PMHP, he or she may be entitled to retroactive Medicaid eligibility. (See SECTION 1 of this manual, Chapter 1 - 3, Retroactive Medicaid). If so, the PMHP contractor will be responsible for services.

Also, unless there are extenuating circumstances, a provider must request authorization from the client's Prepaid Mental Health Plan for inpatient mental health services within 24 hours of admission. If the provider does not have a contract with the PMHP responsible for the inpatient stay, the PMHP may choose to transfer the individual to one of its contracting hospitals.

There are some exemptions for children who need mental health services outside the Prepaid Mental Health Plan to which he or she is assigned. When the child is exempt, the Medicaid card will say:
INPT PSYCH: (Name of PMHP provider)
OUTPT PSYCH: ANY PROVIDER

Physicians who provide outpatient mental health services to an exempt child may bill the CPT-4 codes directly to Medicaid. In some instances, the child's Medicaid card may have already been printed for the month and, therefore, will not yet contain information on the exemption. If you are unsure whether the child is exempt, contact Medicaid Information. For adoptees, contact RueDell Sudweeks, Division of Health Care Financing, at (801) 538-6636.

1 - 2 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

1 - 3 Billing

Physician services may be billed electronically or on paper, using the HCFA-1500 [CMS-1500]claim format. Medicaid encourages electronic billing. Mistakes can be corrected immediately, and your claim is processed without delays. Electronic claims may be submitted until noon on Friday for processing that week.

Providers who use the paper claim form should contact the Utah Health Information Network (UHIN) for standard instructions. Providers may call (801) 466-7705.

1 - 4 Definitions

Definitions of terms used in multiple Medicaid programs are in SECTION 1 of this manual, Chapter 13, *Definitions.* Definitions particular to the physician program are below.

Clinical Laboratory Improvement Amendments (CLIA)
The federal Health Care Financing Administration program which limits reimbursement for laboratory services based on the equipment and capability of the physician or laboratory to provide an appropriate, competent level of laboratory service.

Cognitive services
Non-invasive diagnostic, therapeutic, or preventive office visits, hospital visits, therapy, and related nonsurgical services.

Direct Supervision
The physician must be present and immediately available to render assistance and direction through the time persons under supervision are performing services.

Family Planning
Diagnosis, treatment, medications, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy.

Package Surgical Procedure
The preoperative office visit and preparation, the operation per se, local infiltration, topical or regional anesthesia when used, and the normal, uncomplicated follow up care extending up to six weeks post surgery.

Personal Supervision - Physician Supervision
The critical observation and guidance by a physician of medical services provided by non-physician provider's within their licensed scope of practice, to assure that the health, safety and welfare of patients is not compromised.

Physician Assistant
An individual who meets the applicable education, training, experience, and other state requirements governing the qualifications for assistants to primary care physicians. (42 CFR 405.2401(b) and 42 CFR 491.2)

Physician Services

Services provided in the office, the home, a hospital, or elsewhere, by a physician:

a) within the scope of practice of medicine or osteopathy; and
b) by or under the personal supervision of an individual licensed to practice medicine or osteopathy.

Primary Care

a) basic and general health care services given when a person seeks assistance to screen for or to prevent illness and disease, or for simple and common illnesses and injuries; and
b) care given for the management of chronic diseases. (Utah Code Annotated, Title 26, Chapter 18, Part 3)

Professional Component

That part of laboratory or radiology service that may be provided only by a physician capable of analyzing a procedure or service and providing a written report.

Services

The types of medical assistance specified in Sections 1905(a)(l) through 25 of the Social Security Act and interpreted in the 42 Code of Regulations, Section 440.

Technical Component

That part of a laboratory or radiology service necessary to secure a specimen and prepare it for analysis, or to take an x-ray and prepare it for reading and interpretation.

1 - 5 Co-payment Requirement

Effective November 1, 2001, many adult Medicaid clients will be required to make a co-payment for physician services. Services include those performed in a Federally Qualified Health Center (FQHC). Both HMO and fee-for-service clients can have a co-pay. The client's Medicaid Identification Card will state when a co-payment is required and for what type of services. The provider is responsible to collect the co-payment at the time of service or bill the client. The amount of the client's co-payment will automatically be deducted from the claim reimbursement. Requirements specific to physician services are stated below.

For general information about the co-payment requirement, clients required to make a co-pay, exempt clients, and an example of the co-payment message on the Medicaid Identification Card, refer to SECTION 1 of this manual, GENERAL INFORMATION, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 3, Medicaid Co-payments.

A. Clients Exempt from Co-payments

If there is not a co-payment message under a client's name, the client does not have a co-payment. Also, do not require a co-payment for services to a pregnant woman, even if there is a co-pay message by her name on the Medicaid Identification Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the Medicaid eligibility worker, who can change her co-pay status to exempt on future Medicaid cards.

B. Services Exempt from Co-payments

Clients are not required to make a co-payment for the following types of services:

1. Family planning services.
2. Emergency services in a hospital emergency department.
3. Lab and X-ray services, including both technical and professional components.
4. Anesthesia services.

C. **Co-payment per Medical Visit**

Except for exempt clients and exempt services described in items A and B above, Medicaid clients have a co-payment for physician visits, including a visit in a Federally Qualified Health Center (FQHC).

1 - 6 Prospective Payment System for Federally Qualified Health Centers

The Utah Department of Health, Division of Health Care Financing, will implement, effective January 1, 2001, the Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) as described at Section 1902(a) of the Social Security Act, as amended by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, (H.R. 5661 as incorporated into the Consolidated Appropriations Act, 2001), (PubLNo106-554). For complete information, refer to the special attachment to this manual titled Prospective Payment System for Federally Qualified Health Centers and Rural Health Clinics.

1 - 7 Physician Assistant Services: Limitations

1. Any service limited or excluded from service for physicians is also limited for the physician assistant.

2. The services of an assistant surgeon are specialty medical services to be covered only by a licensed physician and only on very complex surgical procedures. A physician assistant is not authorized to function as an assistant surgeon or as assistants at surgery.

*

3. Other exceptions could be indicated as necessary for supervised physician assistant participation in designated rural areas or in federally designated health professional shortage areas.

4. Physician assistants working in federally designated Rural Health Clinics or Federally Qualified Health Centers function under the federal regulations governing services in such facilities.

5. Physician assistants employed as staff working in locally operated hospitals or clinics are not authorized to have their services separately billed.

2 COVERED SERVICES

Physician services involve direct patient care and securing and supervising appropriate diagnostic ancillary tests or services, within the parameters of established Medicaid policy, to diagnose the existence, nature, or extent of illness, injury, or disability. In addition, physician services involve establishing a course of medically necessary treatment designed to prevent or minimize the adverse effects of human disease, pain, illness, injury, infirmity, deformity, or other impairments to a client's physical or mental health.

1. Supervision by a Physician

   Physician's services must be personally rendered by a physician licensed under state law to practice medicine or osteopathy, or by an individual licensed to serve the health care needs of a practice population under a physician's supervision.

   a. "Physician Supervision" means:

      The critical observation and guidance by a physician of medical services provided by non-physician providers within their licensed scope of practice, to assure that the health, safety and welfare of patients is not compromised.

      The acceptable standard of supervision is availability by telephone when the physician maintains written protocols embodying care standards and supervisory procedures along with the Delegation of Services Agreement maintained at the practice site. Medical records must have sufficient documentation signed by the physician to reflect active participation of the physician in supervision and review of services provided by staff under supervision.

   b. "Direct Supervision" means:

      The physician must be present and immediately available to render assistance and direction through the time persons under supervision are performing services.

      When licensure laws, policy, education protocols, coding definitions, or service being provided require "Direct Supervision", the acceptable standard of supervision is availability in the facility, not necessarily within the same room, but within 10 minutes of reaching the person being supervised to provide assistance, consultation or direct care. Medical records must have sufficient documentation signed by the physician to reflect presence and participation of the physician in direct supervision.

2. Physical examinations are covered only in the following circumstances:

   a. Preschool and school age children, including those who are EPSDT (CHEC) eligible, participating in the ongoing CHEC program of scheduled services and follow-up care.

   b. New patients seeing a physician for the first time with an initial complaint where a physical examination, including a medical and social history, is necessary.

   c. Medically necessary examinations associated with birth control medication, devices, and instructions for those of childbearing age, including sexually active minors.

3. After-hours office visit codes, 99050, 99052, 99054, and 99058 may be used by a private physician, primary care provider, who responds to treat an established patient in the physician's private office for a medical emergency, accident or injury after regular office hours. A private physician or physician group with established evening/weekend office hours, or a free-standing urgent care facility which operates as a physician office, may also use these after-hours service codes. Only one of the after-hours office codes can be used per visit in addition to the E/M or service code.

   Limitations on use of the after-hours office visit codes

   Limitations on use of the after-hours office visit codes are:
   a. They cannot be used in a hospital setting, including the Emergency Department, by a private or staff physician under any circumstances;

   b. They cannot be used for standby or waiting time for surgery, delivery, or other similar situations;

   c. They cannot be used when seeing a new patient.

4. Surgical procedures are covered as "package" or global services. The package service and payment includes:

   a. All pre-operative and post-operative education and training related to the surgery. Associated education and training cannot be billed to either the Medicaid program or the Medicaid patient separately. Billing for these services is prohibited under Section 1, subsection 11-3(C) of the Medicaid physician provider manual.

   b. The preoperative examination, initiation of the hospital record, and development of a treatment program either in the physician's office on the day before admission, or in the hospital or the physician's office on the day of admission to the hospital;

   c. The operation per se;

   d. Any topical, local, or regional anesthesia; and

   e. The normal, uncomplicated follow-up care covering the period of hospitalization and office follow-up for progress checks or any service directly related to the surgical procedure for up to six weeks.

   f. Interpretation: A physician may not bill for an office visit the day prior to surgery, for preadmission or admission work up, or for subsequent hospital care while the patient is being prepared, hospitalized, or under care for a "package" service.

   g. Procedures identified as "add on" will be adjudicated according to the multiple surgery ranking.

   Note: The Medical and Surgical Procedures List and Criteria For Medical And Surgical Procedures included with this manual contains a complete list of covered surgical procedures and criteria to be used to determine coverage.

5. Surgical services requiring prior authorization but provided under emergency circumstances as a life saving measure will be considered for coverage by an "after the fact review". Sufficient documentation as outlined in Chapter 4 - 1, Retroactive Authorization, of this Section must be provided in order to make an appropriate review of the circumstances and determination of coverage. Additional information on the authorization process may be found in SECTION 1 of this manual, Chapter 9, Prior Authorization Process.

6. Consultation services are covered for a consulting physician only when consultation and no other service are provided. When a consulting physician admits and follows a patient, independently or concurrently with the primary physician, only admission codes and subsequent care codes may be used.

7. Preoperative examination and planning are covered as separate services only in the following circumstances:

   a. When the preoperative visit is the initial visit for the physician, and time is required for evaluation to establish a diagnosis, determine the need for a specific surgical procedure, and explain details to the patient;

   b. When the preoperative visit is a consultation and the consulting physician does not assume care of the patient; or

   c. When diagnostic procedures, not part of the basic surgical procedure, are determined necessary during the immediate preoperative period.

8. Procedures exempt from the "package definition" are starred procedures (*) identified in the CPT Manual. These procedures are relatively minor and have variable pre and post-operative periods. Therefore, separate payment for an E/M visit may be made.

9. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring service concurrent with the initial surgical procedure during the listed period of normal follow-up care, may warrant additional charges only when the record shows extensive documentation and justification for the complexity of the additional services.

10. When additional medically necessary surgical procedures, adjunct to the initial procedure, are carried out within the listed period of follow up care for the initial surgery, the follow up periods continue concurrently to their normal terminations.

11. The services of an assistant surgeon are speciality services to be provided only by a licensed physician and covered only on very complex surgical procedures. A listing of procedure codes which are not authorized are in the list titled Procedures Not Authorized for Assistant Surgeon which is included with this manual.

    If there are extenuating circumstances involved in a case, a physician may request a review of the case by the Medicaid physician consultant for consideration for payment of an assistant. In such cases, a copy of the history and physical exam, the operative report, the pathology report and the discharge summary must be submitted to the Utilization Management Unit for review.

12. An evaluation and management (E/M) code and a diagnostic procedure code will generally not be covered separately on the same date of service. This includes service in the Emergency Room.

13. Diagnostic procedures performed along with larger, major therapeutic procedures are considered incidental to the major procedure, and no additional payment is warranted. Examples are a diagnostic laparoscopy and an open surgical procedure, or a diagnostic arthroscopy and a surgical arthroscopy. Payment will not be made for both procedures on the same day or during the same operative session.

14. Separate procedures as identified in the CPT guidelines are commonly carried out as an integral part of a total service and, as such, do not warrant separate payment. However, these procedures have the potential to be carried out independently of other services. In such cases, when a service is identified as a separate procedure, and it is the only procedure provided for a patient on a single date of service, separate reimbursement may be made.

15. A modifier provides a means by which a physician can indicate that a service or procedure has been altered by some specific circumstances, but not changed in definition or code. Modifier definitions and instructions for use are found in the CPT Manual. Some limitations may apply.

16. Unusual services or those requiring excessive time or resources can be considered for coverage by use of the 22 modifier. A prepayment review of the unusual circumstances will be completed by Medicaid professional staff and medical consultants. Supporting documentation described in SECTION 1 of this manual, Chapter 9 - 1, Unspecified Services and Procedures, must be submitted with the claim for review.

17. Medically necessary services for complications of non covered or non-authorized procedures which are done at the choice of provider or client will be considered for coverage only after normal recovery period for the procedures has passed. Coverage will be determined by medical review of the procedure, the circumstances, and the complications. Established criteria will be used in the review.

18. Coverage of drugs and biologicals is based on individual need and orders written by a physician when the drug is given in accordance with accepted standards of medical practice and within the protocol of accepted use for the drug. Coverage requirements are described in the Utah Medicaid Provider Manual for Pharmacy Services. A copy of the Pharmacy Manual may be obtained on the Internet through a link on the Medicaid Provider's Guide http://health.utah.gov/medicaid/provhtml/provider.html, or contact Medicaid Information.

    a. Medicaid covers most medications prescribed by qualified practitioners as a Medicaid benefit, in compliance with Federal law (42 CFR 440.120).

    b. Medicaid has additional requirements for drugs identified on the Drug Criteria and Limits List attached to this manual, including limits or requirements for prior authorization.

    c. Nonprescription, over-the-counter items are limited to those OTC drugs on the Over the Counter Drug List attached to this manual.

    d. Effective January 1, 2002, Medicaid limits coverage of prescriptions to a maximum of seven prescriptions a month for most adult clients, including nursing home patients. The limit includes scripts for over-the-counter medications. Medicaid exempts certain clients and certain drug classes from the prescription limit. The Drug Criteria and Limits list, an attachment to this manual, describes both the Medicaid clients and the drug classes which are exempt.

19. Generic drugs shall be used whenever a generic product approved by the FDA is available. Brand name drugs are covered only when a documented medical reason exists which prevents use of the generic product. Medical necessity must be verifiable. If the physician determines that a brand name drug is medically necessary, the physician may override the generic requirement by writing on the prescription in his own hand writing "Brand Name Necessary" or a similar statement. [42 Code of Federal Regulations § 447.331© and § 447.331(c)(3)].

    Patient preference does not constitute a medical necessity. A patient who prefers a name brand may obtain the more costly product by paying the pharmacist the difference between the cost of the generic (MAC) product and the cost of the name brand (EAC).

    If the prescription does not meet coverage requirements, brand name reimbursement is not covered. Examples of prescriptions which are not acceptable for a 'dispense as written' prescription are a prescription without the required order in the physician's handwriting, including a telephone prescription; signature boxes; letters such as "DAW;" abbreviations such as "no sub;" preprinted information; and instructions from someone other than the physician. Telephone prescriptions where the brand is medically necessary must receive written instructions from the physician before a brand name may be billed.

    Medicaid conducts a post-payment review of pharmacy records to ensure that a prescription required a brand name drug to be dispensed, by physician's override procedure, instead of a generic drug.

20. Injectable medications approved in HCPCS are identified in the Injectable Medications List. The list is included with this manual.

21. The injectable medication code, or J - Code, covers only the cost of an approved product.

22. An injection code which covers the cost of the syringe, needle and administration of the medication may be used with the injectable medication code, or J - Code, when medication administration is the only reason for an office call.
    Note: An office visit, J - Code, and an administration code cannot be used all for the same date of service. Only two of the three codes can be used at any one time or at any one visit.

23. Chemotherapy Administration.

    When a visit to the physician's office is for administration of a medication or chemotherapy agent, only the J code for the medication and the administration code (96400-96549) will be paid. An office visit will not be paid. The administration fee covers the skill, evaluation, and management required to administer the chemotherapy agent. However, effective October 1, 2001, when significant, additional service meeting the level of the evaluation and management (E&M) code is provided on the same date of service, the E&M code may be paid in addition to the J code and administration code. Use modifier 22 when the claim is submitted and include the medical record documentation for staff review.

24. Methylphenidates, amphetamines, and other central nervous system stimulants require prior authorization and may be provided to both children and adults under very strict protocols. Refer to the Drug Criteria and Limits List attached.

25. Nutrients are covered only for patients with a missing or damaged digestive organ who require total nutrition.

26. Surgical supply reimbursement is included in "package" surgical procedures in an office. Separate payment will not be made.

    Procedure code 99070 will not be covered for the purpose of obtaining "incidental supplies" for procedures provided in the office. This code is incidental to the office visit and/or service, and additional payment will not be made.

27. In the occasional, unusual circumstance that additional supplies may be warranted by the nature of the surgical procedure performed, a surgical tray can be billed using code A4550.

28. **Supplies and Equipment from a Medical Supplier**

    Procedure code 99070 is intended to cover one incidental item per day. Payment for this code is very minimal. It is intended to be used for incidental supplies not covered under an otherwise covered procedure completed during an office visit. This code is not intended to be a miscellaneous code for billing medical supplies or equipment available from a medical supplier.

    a. The Utah Medicaid Program covers medical supplies and equipment under four conditions: (1) The supplies and equipment are medically necessary; (2) they are ordered by a physician; (3) they meet the standards stated in policy and the Medical Supplies List, and they are within the limits specified; and (4) they are on the Medical Supplies List included with this manual. Coverage requirements are described in the Utah Medicaid Provider Manual for Medical Supplies. A copy of this manual may be obtained by contacting Medicaid Information.

(1) Medical necessity does not include use primarily for hygiene, education, exercise, convenience, cosmetic purposes, or comfort. The physician's order must list each item required, a medical necessity, and be signed and dated by the physician or other licensed medical practitioner. An item simply marked on a preprinted multiple item order sheet is not acceptable.

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b. The Child Health Evaluation and Care (CHEC) Program may approve medical supplies and medical equipment which are medically necessary for children less than 21 years of age. For specific information, please refer to the Utah Medicaid Provider Manual for Child Health Evaluation and Care (CHEC) Program Services. A copy of this manual is available on the Internet through a link on the Medicaid Provider's Guide http://health.utah.gov/medicaid/provhtml/provider.html, or contact Medicaid Information.

29. Medicaid restricts hemophilia blood factors to a single provider. The purpose is to provide a uniform hemophilia case management support program to the patient and patient's physician and to achieve economies in the purchase of blood factor through a sole source contract. Medicaid will reimburse only the sole source provider for hemophilia case management, blood factors VII, VIII and IX. No other provider will be paid for blood factors VII, VIII or IX supplied. Medicaid clients who choose not to participate in the Medicaid Hemophilia program must make their own arrangements for procurement and payment of the blood factor.

    The contract affects only the procurement and management of the prescribed blood factor. The patient's physician continues to be responsible to develop a plan of care and to prescribe the blood factor. The contract with the sole source provider specifies the provider must work closely with the patient's Primary Care Provider physician or managed care plan.

    Managed care plans which contract with Medicaid continue to be responsible for hemophilia-related services such as physical therapy, lab work, unrelated nursing care, and physician services.

    As of October 2000, the sole source provider is University Hospital Home Infusion Services. Please direct questions concerning hemophilia case management and blood factors VII, VIII and IX to this provider: 801 - 466-7016.

30. Telemedicine or telehealth services are an additional method of delivering health care to patients in under served rural areas. Medicaid views telemedicine no differently than an office visit or outpatient consultation. However, if there are technological difficulties in preforming an objective thorough medical assessment, or problems in patient understanding or acceptance of telemedicine, hands-on-assessment and/or care must be provided for the patient. Quality of health care must be maintained regardless of the mode of delivery.

    For Medicaid reimbursement, University of Utah telehealth connections to rural areas must be located within Utah, and health providers must be licensed in Utah.

    Definitions

    Telemedicine or telehealth is a technological method of providing an auditory and visual connection between the consultant at a remote site and the patient who is assisted by a Health Department clinician at the rural Health Department clinic.

    Authorized providers: The University of Utah telehealth site will provide access for physician and dietitian consultation. Health care providers are limited to physicians and dietitians during the beginning of the Children's Special Health Care Needs pilot project. Other speciality areas may be added later as the project continues.

    Covered Services

    Medically necessary diagnostic and therapeutic services, appropriate for the adequate diagnosis or treatment of some Special Health Care Needs Children, are covered services. The services include initial physician consultation, confirmatory consultations, and follow up consults. The service and codes will be limited to those which might be appropriate for evaluation and consultation without hands-on-care.

    Limitations

    - For Medicaid and the Special Health Care Needs Children project purposes, health care delivery through telehealth is only relevant for Special Health Care Need's Children residing in rural areas. It provides the child with access to a health provider specialist in an urban area without travel from the rural area. Health Department clinics in Milford, Price, and Richfield with telehealth connections to the University of Utah telehealth site are eligible for inclusion in the project.

    - Providers are limited to physicians and dietitians working through the University of Utah telehealth site as participants in the Special Health Care Needs Child project. Each health provider must have a medicaid provider number.

    - Providers will ensure that the legal guardian of the Special Health Care Needs Child signs a consent to authorize the child's participation in the telehealth project. Without signed consent, the child is not eligible to participate in telehealth.

Billing/Payment

Bill on a HCFA 1500 Claim form.

All payments will be made to the Bureau of Children with Special Health Care Needs in the Division of Community and Family Health Services, Department of Health.

No payments will be made for telehealth transmission expense or facility charge.

Codes

Codes which may be used by telemedicine physician consultants:

- 99201-99205 - initial outpatient consultations
- 99211-99215 - outpatient established patient

Codes which may be used for dietician consultation:

- S9470 dietician nutritional counseling
  This is a new code which specifically describes dietician education and consultation for Special Health Care Needs Child during the telehealth project. Dietician consultation for the family will average four per year.

Modifier

GT Each dietician and physician provider consultant must add the GT modifier to indicate the service was provided through telehealth. This modifier is required to monitor and evaluate the financial impact of this project.

Non-Covered Modifiers

*

GQ This modifier is used for transmission of data such as radiology or electrocardiogram. This is not a covered service for the Medicaid Telehealth Special Health Care Needs Child project.

31. Diabetes Self-Management Training

Effective October 1, 1999, code S9455, Diabetes Self-Management Training, is available for use by authorized diabetes self-management providers. Patient preauthorization is required to receive diabetes self- management training.

Patient Preauthorization

A newly diagnosed patient with Type I, Type II, or gestational diabetes or a patient previously diagnosed with Type I or Type II diabetes, is eligible to receive diabetes self management training through Medicaid when:

- The physician provides a referral for the patient who has never had a diabetes self management training course. The course is limited to 10 sessions. Services are billed under code S9455.
- The patient completed the diabetes training at least 12 months ago, and the physician refers the patient for a specified number of refresher diabetes training sessions because:
  1. The patient has progressed in diabetes illness to require further management training or the patient has indications they are noncompliant with treatment.
  2. Patient has complications of diabetes requiring two or more visits to the emergency room during the last six months or a hospital admission related to diabetes within the last year.

At preauthorization the following patient information should be provided:

- Patient is informed of the importance of completing the series of classes and agrees to sign a contract agreement to make every attempt to follow through with education sessions.

- The patient is informed that if they do not complete the classes, there is a one year waiting period before further classes will be authorized.

Authorized Providers

Diabetes self management training must be provided through a state or nationally recognized provider. Providers **must** obtain authorization to become a recognized provider for diabetes self management training.

1. Providers who may become recognized for reimbursement include:

   A. an American Diabetes Association (ADA) recognized program or ADA certified diabetes educator.

      Individuals or entities interested in recognition from Education Recognition Program (ERP) should contact the ADA's national office at 1-888-232-0822.

      OR

   B. a Utah State Department of Health-certified educator.

      Individuals or entities interested in Health Department certification should contact the Chronic Disease Diabetes Program at 538-6141.

2. The diabetes self training program must be taught by a registered nurse and certified dietician. Therefore a copy of the license/certification of the registered nurse and dietician providing the training within the program are required in order to obtain a group provider number.

32. Maternity Care

Maternity Care is a global service billed with an appropriate code at the conclusion of pregnancy. Maternity care is generally routine and uncomplicated, but can be associated with risk factors which must be managed. Treatment of complaints that accompany most pregnancies including, but not limited to, nausea, vomiting, backache, headache, lumbago, cystitis, urinary tract infection, malaise, mild anemia, etc., must be included as part of the routine care and not billed as separate service.

A. Antepartum Care

The initial office visit to a physician is not a separate billable service. It must be included as part of the global maternity service. Special laboratory work at the time of the initial visit is an exception, but must be billed by the laboratory completing the tests and not by the physician.

Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressure, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery.

B. Labor and Delivery

Services include admission to the hospital, history and physical, management of labor, and the delivery -- vaginal, with or without forceps, or cesarean section delivery.

1. **False labor**
   False labor may occur after 37 completed weeks of gestation. At this point in a pregnancy, changes begin to occur, and contraction-like activity may be present. It is often difficult to identify true labor, especially for a first time mother. If the threatened labor is of such a nature that a hospital admission is determined necessary by the physician, but does not progress to delivery through the current admission, a payment separate from the global maternity fee can be made for the service. The hospital should identify the admission with ICD.9.CM code 644.13 and appropriately selected Evaluation and Management codes. Repeated admissions through the final three weeks of pregnancy will be reviewed through the post payment review process.

2. **Woman with an Emergency Services Only Card**
   Only labor and delivery codes are billable for an woman with an Emergency Services Only card. Other maternity care services (prenatal and postpartum) are not payable as an emergency. Physicians may be reimbursed for the following procedure codes under the Emergency Services Only Program:
   - High Risk delivery: Y7052, High-risk delivery only, or Y7053, High-risk delivery only, Cesarean
   - All other deliveries described by the following CPT procedure codes: 59409, 59514, 59612, 59620

   For more information on the Emergency Services Program, refer to SECTION 1 of this manual, Chapter 13 - 6, Emergency Services Program For Non-Citizens.

C. Postpartum Care

Includes hospital and office visit follow up for up to six weeks following the delivery.

D. Complications

Complications during the antepartum, labor or delivery period may be significant enough to compromise the pregnancy, the mother or the fetus. To warrant consideration for additional payment such complications should be of major significance, separately identifiable by an ICD.9.CM diagnosis code, require separate and distinct therapy from the usual services of pregnancy, and be clearly identified in the record. (Some examples are hyperemesis gravidarum with metabolic disturbance; diabetes mellitus, uncontrolled; eclampsia; severe anemia with systemic implications; pre-term labor; or drug dependence

E. High Risk Pregnancy

When complications or risk factors pose a risk to the pregnancy, the circumstances should be carefully documented, and a risk assessment form submitted for billing to assure payment for services. Billing for the risk assessment must be received before a high risk delivery can be billed.

Two risk assessments can be completed and billed during a 10-month period. One assessment should occur at intake and another at 36-38 weeks gestation or earlier if problems arise. (The full risk assessment policy is in the Utah Medicaid Provider Manual for Enhanced Services to Pregnant Women.)

1. Codes

In addition to the codes for Maternity Care found in the CPT Manual, the following codes are also available for use:

Y7006 Risk Assessment (Limited to two)
Y7050 High - risk vaginal delivery (global)
Y7051 High - risk cesarean delivery (global)

2. Other Services

Other medical problems treated by the obstetrical provider for a pregnant woman which are not related to the pregnancy, may be covered by using the appropriate ICD.9.CM diagnosis code and an evaluation and management office visit procedure code.

Fetal Non-stress Test (code 59025) will be covered only for clinically documented high-risk pregnancy. Use of this test is considered appropriate for, but not limited to, patients who have hypertension, diabetes, other systemic diseases, a history of previous stillbirth, or when there is a decrease or absence of fetal movement.

Indications, repetition, frequency and utilization of the fetal non-stress test will be evaluated through documentation in the record of any pregnancy case being reviewed.

3. Incomplete Obstetrical Care

When a physician provides all or part of the antepartum care, but does not complete the delivery due to termination of pregnancy or referral to another physician, one of the antepartum codes (only one) in the CPT Manual which covers the number of antepartum visits provided can be billed.

4. Services for pregnant women not eligible for Medicaid

Women who do not meet regular United States residency requirements (undocumented) are eligible only for the Emergency Services Only Program. Labor and delivery are considered emergency services. Only labor and delivery will be covered. Prenatal care cannot be reimbursed with Medicaid funds.

"Emergency Services Only " is printed on the Medicaid Identification Card. Information about the program can be found in SECTION 1 of this manual, Chapter 13 - 6 Emergency Services Program For Non-Citizens. An example of this card is included with the attachments to this manual.

F. Coding for Maternity Care

The Physician's Current Procedural Terminology Manual (CPT) and the Medicaid Physician Provider Manual have significant information on appropriate coding for maternity services. The following is additional information on appropriate coding.

1. Global fee

The services provided in uncomplicated maternity care should be covered by a global fee as the standard. The global fee should not be broken up and billed with separate components unless the appropriate circumstances warrant it. When a physician does not provide complete prenatal service, care should be taken to assure proper selection of codes to appropriately bill for the services provided.

2. Change of Provider

Patients do change care providers whether by referral or by choice.

(a) Less than three visits to one provider at the beginning of a pregnancy should be billed by the initial provider using regular E/M codes.

(b) When a patient goes to a second provider, voluntarily or by referral, the second physician should carefully consider whether or not it is a true referral. There should be clear documentation from the referring physician, verifying referral and his plans to bill the E/M codes or one of the prenatal codes (59425 or 59426).

(c) The accepting provider should select appropriate billing codes based on the number of visits, the delivery and postpartum care. Seven or more visits, the delivery and postpartum care should be billed as the global service. (Billing by using code 59426, a vaginal or C-section delivery code and separate postpartum code (59430) by the same physician should never be submitted.)

(d) Billing of codes 59425 and 59426, for the same patient during the same pregnancy should never be submitted.

(e) Billing of code 59425, plus a vaginal or C-section delivery code with postpartum care would be unusual, but could be a possibility if only 4 to 6 prenatal visits are provided.

(f) Postpartum care only code 59430 is a separate procedure code and should be used only when no other prenatal or delivery service is provided by a physician.

(g) One of the prenatal care codes (59425 or 59426) could be used in conjunction with the postpartum care code (59430) providing the physician billing these codes did not provide the delivery.

(h) A delivery only code (59409 or 59514) could be used by a physician who only completes the delivery and no other service. (Probably on an emergency basis.)

(i) One ultrasound in pregnancy at about 18 - 20 weeks of pregnancy is allowed without prior authorization. When the patient experiences complications at less than 14 weeks gestation, one ultrasound is allowed without prior authorization in addition to the one at 18 - 20 weeks. Other ultrasounds will require prior authorization. Refer to the Criteria For Medical And Surgical Procedures, Criteria #39, Ultrasound in Pregnancy.

3. Group Practice

Maternity care involving group practice or physicians taking call and covering for each other, presents some unique issues. The practice relationships and office organization dictates how billing will be handled.

(a) one physician covering for another completes the delivery.

(1) One appropriate billing solution, in compliance with stated policy, codes the delivery only using 59409 or 59514. The physician who provided the appropriate number of prenatal visits and postpartum care then bills for that service.

(2) A different billing approach may be more appropriate for a practice relationship and office organization, established by contract or other agreement, which is a cooperative group practice. The billing and payment questions even out in the long run . Unless there is a complete turnover of the case from one physician to another or to another group, the global billing can be maintained.

(b) Can a physician bill a global fee and pay a second physician for the part of the service he provided?

No. This conflicts with SECTION 1 of this manual, Chapter 6 - 6, Billing Medicaid, which states:

> "The provider may bill Medicaid only for services which were medically indicated and necessary for the patient and either personally rendered or rendered incident to his professional service by a employee under immediate personal supervision . . . ."

Physicians are not usually employed by each other, nor do they supervise each other. If each physician is to be paid individually and not under a group practice arrangement, each should complete the individual billing and receive payment accordingly.

33. Neonatal and Pediatric Critical Care Services

Effective January 1, 2003, some significant changes were made in the CPT codes for Neonatal and Pediatric Critical Care Services including:

- Introduction of codes 99293 and 99294 as new pediatric critical care codes
- Discontinuation of 99297 as a neonatal critical care code
- Redefinition of code 99296 to be used to bill for subsequent care for both stable and unstable neonates requiring critical care
- Introduction of 99299 as a new neonatal intensive care code for service to the infant with body weight between 1500 and 2500 grams

These Neonatal and Pediatric Critical Care Codes are bundled (global) codes to be:

- used only to bill for care required by neonates/infants between birth and 24 months of age who require critical care or intensive care services
- billed only once for each 24-hour period
- inclusive of a broad range of services rendered by all physicians involved in the health care team which provides continuous management and care for the infant/child during the 24-hour period

Provision of services and coding is selectively limited to Board Certified Neonatologists, Board Certified Pediatric Intensivists, High Risk Pediatricians, or Board Certified Pediatricians depending on the level of care required.

Definitions

Critical Care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. Critical Care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition.

Board Certified Neonatologist is a pediatric sub-specialty achieved beyond the primary care pediatric certification, completion of an additional three year fellowship program in neonatology, and successful completion of the certification examination from the sub-board of Neonatal/Perinatal Medicine of the American Board of Pediatrics.

Pediatric Intensivist (PICU) is Board Certified in Pediatrics by the American Board of Pediatrics, followed by a three year fellowship in Pediatric Critical Care and certified in Pediatric Critical Care Medicine at an institution accredited by the Residency Review Commission of the American Association of Medical Colleges. And must provide a cirtificate showing certification from the Sub-board of Pediatric Critical Caare Medicine of the American Board of Pediatrics. The PICU Intensivist specializes in the care of the infant 31 days to 24 months of age. (This provider type may not be available in all locations, if not, only the Board Certified Neonatologist can provide the care as designated.)

Board Certified Pediatrician is a specialist in pediatrics with current licensure in the state as a MD, has successfully completed the certification examination from the American Board of Pediatrics and is actively participating in a pediatric practice.

High Risk Pediatrician is a board certified pediatrician who has completed at least 3 months of NICU experience during pediatric residency, has current certification in Neonatal Resuscitation Program (NRP), completes ten hours of continuing medical education each year focused on neonatal medicine, and maintains neonatal medicine practice skills by providing NICU care for at least 30 patient days per year or participation for at least 30 days with a NICU team.

Program Coverage

Neonatal Critical Care Codes: 99295 - 99296

The descriptors for CPT codes 99295 (Initial neonatal critical care) and 99296 (Subsequent neonatal critical care) have been altered slightly. 99296 applies only during the first 30 days of life. Only neonatologists and pediatric intensivists who are board certified are authorized by Medicaid to bill under these codes.

Pediatric Critical Care Codes: 99293 - 99294

CPT codes 99293 (Initial pediatric critical care) and 99294 (Subsequent pediatric critical care) are new codes, which address a new group of critically ill infants or young children who are at least 31 days of age, but not older than 24 months of age. The infant no longer meets the neonate definition but requires continuing intensive care/critical care management. Both codes are bundled (global), 24-hour codes.

Code 99293 applies on the day of admission for infants age 31 days to 2 yrs who are admitted directly into the intensive care unit (NICU or PICU) from outside the hospital because of their need for pediatric critical care (including the same elements defined under the neonatal critical care codes 99295 and 99296).

Code 99294 applies to either of the following two groups of patients:

- Infants admitted as neonates under 99295 and billed under 99296 until they reach 31 days of age and who require continued critical care
- Subsequent critical care provided to infants admitted under 99293

Only neonatologists and pediatric intensivists who are board certified are authorized by Medicaid to bill under these codes.

Intensive (Non-Critical) Low Birth Weight Services: 99298 and 99299

This is a new category of service established for the physician directing the continuing intensive care of the very low birth weight (VLBW) or low birth weight (LBW) infant who no longer meets the definition of critically ill, but continues to require intensive observation and frequent services and interventions only available in an intensive care setting. Both codes are bundled (global), 24-hour codes.

Code 99298, which was previously included under neonatal critical care codes, but has now been shifted to the new Intensive (Non-Critical) Care category. This code includes recovering very low birth weight (present body weight less than 1500 grams) infants requiring evaluation and management and continued monitoring and observation by the health care team under direct physician supervision. Only neonatologists, pediatric intensivists, and High Risk Pediatricians, board certified in their specialty, are authorized by Medicaid to bill under these codes.

Code 99299 is a new code for subsequent intensive care and management of recovering low birth weight (present body weight of 1500-2500 grams) infants, who require evaluation and management and continued monitoring and observation by the health care team under direct physician supervision. Neonatologists, Pediatric Intensivists, High Risk Pediatricians, and Pediatricians who are board certified in their specialty are authorized by Medicaid to bill under this code.

Recovering Neonates – Service to infants whose body weight exceeds 2500 grams, are not critically ill, but still in a guarded condition and in need of continuing critical care can continue to be served under codes 99298 and 99299 as long as the medical record reflects the need and the intensive care provided. Service in this category with use of code 99298 can be provided by board certified neonatologists, board certified pediatric intensivists or high risk pediatricians. Code 99299 can be utilized by all of the above physicians and the board certified pediatrician.

If critical/intensive care is not required and growth and weight gain are the needs of the recovering neonates, standard Evaluation and Management codes 99221 - 99223 or 99231 - 99233 should be used with appropriate documentation and billed similar to other pediatric and neonatal intensive care codes as a global service. Service in this category can be provided by Board Certified Pediatricians, Board Certified Neonatologists, Board Certified Pediatric Intensivists, or High Risk Pediatricains..

Notes:

a. Care codes in any of the categories of service may not be assigned based only on a diagnosis, birth weight or a level of nursing care, but rather on the type of monitoring, available technology, and experience of available physician and supporting staff as it relates to the complexity of medical decision making.

b. Services to a child over the age of 24 months admitted and in need of critical care are subject to use of the regular Critical Care codes 99291 and 99292.

34. Anesthesia and Postoperative Pain Management Services

    For information regarding coverage of anesthesia and postoperative pain management services, refer to **SECTION 3, Anesthesia**.

35. Laboratory Services

    For information regarding coverage of lab services, refer to **SECTION 4, Laboratory Services**.

3 LIMITATIONS

Physician services may be provided only within the parameters of accepted medical practice and are subject to limitations and exclusions established by the Department on the basis of medical necessity, appropriateness, and utilization control considerations.

The current edition of the Physicians' Current Procedural Terminology Manual (CPT) published by the American Medical Association, the Health Common Procedure Coding System (HCPCS) published by the Health Care Financing Administration, and some state specific "Y" codes are used to code and define covered Medicaid services. Some limitations apply:

A. Cognitive services by a provider are limited to one service per client per day. These services are defined in the CPT Manual as office visits, hospital visits except for those following a package surgical procedure, therapy visits, and other types of nonsurgical services. When a second office visit for the same problem or a hospital admission occurs on the same date as another service, the physician must combine the services as one service and select a procedure code that indicates the overall care given.

B. Routine physical examinations are limited to:

- preschool and school age children, including those who are EPSDT (CHEC) eligible under the age of 21, participating in the ongoing CHEC program of scheduled services and follow-up care.

- New patients seeing a physician for the first time with an initial complaint where an examination and a medical and social history is necessary.

- Medically necessary examinations associated with birth control medications, devices, and instructions for those of childbearing age, including sexually active minors.

C. Coverage of some procedures identified by CPT codes is limited because of the nature, intensity, or relationship to other procedures performed during or related to other services.

1. A minor procedure, in some cases, will be considered incidental to the E/M service, and the E/M code will be paid.

2. A duplicate procedure is the same procedure performed on a patient on the same date of service by the same provider and will be denied.

3. Mutually exclusive procedures are two or more procedures that are usually not performed during the same patient encounter on the same date of service. The less clinically intense procedure(s) will be denied.

4. Incidental procedures are relatively minor procedures performed at the same time as complex primary procedures and are clinically integral to the performance of the procedure. Therefore, the incidental procedure does not warrant additional payment.

5. Medical and Surgical Procedures identified by CPT code may only be provided by the physician or osteopath. Procedures may not be completed by ancillary personnel including nurse practitioners and physician assistants, unless a specific exception for a specific code is described as Medicaid policy in this manual.

D. Modifiers as defined in the CPT Manual have some limitations in Medicaid policy. Current edits are applicable and will remain. New limitations are implemented with the clinically based auditing program.

1. Modifier 25 will not be recognized as a stand alone entity to override the one service per day Medicaid policy. If a significant, separately identifiable E/M service or another service is necessary on the same day by the same provider, rather than using modifier 25, the service can be identified with its own unique ICD.9.CM diagnosis code and be appropriately documented in the medical record. The claim will deny because of the two services on one day. Documentation may be submitted for review to verify the service. Significant, separately identifiable E/M service will be the emphasis of the review to determine if both services are appropriate for payment.

2. Modifier 57 will not be recognized. Decision for surgery is integral to office visits covered before or immediately prior to the preoperative office visit that is part of the surgical global fee.

3. Modifier 27 will not be recognized. Modifier 27 has been redefined relative to the Medicare hospital outpatient payment system. Since Medicaid does not use this payment system, Modifier 27 is not valid for Medicaid services.

E. Laboratory procedures

Laboratory services provided by a physician in his office are limited to the waived tests or those laboratory tests identified by the Health Care Financing Administration for which each individual physician is CLIA certified to provide, bill and receive Medicaid payment.

When the Affirm Test for DNA probes, CPT codes 87660, 87510, or 87480 are billed, only one of the three codes will be paid to the physician.

Unspecified laboratory codes will no longer be accepted when there is a specific test available. The specific test must be ordered for reimbursement. Examples of this policy include:

- **The code 87797–Infectious agent not otherwise specified; direct probe technique will no longer be accepted when the test completed is Trichomonas vaginalis, direct probe, code 87660.**
- **The code 87800–Infectious agent detection, direct probe technique will no longer be accepted when the test is Chlamydia trachomatis, direct probe, code 87490.**

Clinical diagnostic laboratory tests that are sent to an outside independent laboratory to be completed must be billed by the laboratory completing the service. The physician cannot bill for these services and seek payment from Medicaid.

– Urinalysis using a code like 81002 is incidental to an office visit and use of an appropriate E/M code.

– Blood Gas determination (82800) is considered clinically integral to the primary procedure, anesthesia, or critical care. No additional payment will be made for this procedure.

– Pulse oxymetry (94760) is a non-invasive measurement of oxygen saturation which requires a minimal amount of time and is considered incidental to an E/M code or anesthesia administration. No additional payment will be made for this procedure.

F. A specimen collection fee is limited only to specimens drawn under the supervision of a physician to be sent outside of the office for processing and only to specimens collected by one of the following methods:

- Drawing a blood sample through venipuncture, i.e., inserting a needle attached to a syringe into a vein and withdrawing a sample of blood. (Code 36415 is used to bill this fee.)

  or
- Collecting a urine sample by catheterization.

1. Venipuncture is not a covered service when finger or heel sticks are done for a reagent strip test with codes like the following:

   82948, blood glucose by reagent strip
   82962, glucose blood home monitoring device
   83036 with QW modifier, glycated hemoglobin
   85013, spun microhematocrit,
   85014 with QW modifier, hematocrit
   85610 with QW modifier, prothrombin time
   86318 immunoassay for infectious agent by reagent strip

None of these are venipuncture procedures. Therefore, code 36415 for venipuncture will be considered mutually exclusive to any of the CPT codes used for reagent strip testing. However, if other blood specimens are ordered which require venipuncture, 36415 payment will be allowed.

2. Obtaining a pap smear is limited to and included in the reimbursement for an office visit. A specimen collection fee is not separately billable for this service.

G. Finger/heel/ or ear sticks are limited only to infants under the age of two years by use of CPT Code 36416.

H. Eye examinations are limited to one each calendar year.

I. Contact lenses are covered only for aphakia, nystagmus, keratoconus, severe corneal distortion, cataract surgery and in those cases where visual acuity cannot be corrected to at least 20/70 in the better eye. Contact lenses will not be provided for moderate visual improvement and/or cosmetic purposes.

J. Psychiatric services or psycho social diagnosis and counseling are specialty medical services, and whether provided in a private office, a group practice, or private clinic are limited to direct provision, documentation and billing by the private physician. Charting and documentation must clearly reflect the private physician's direct provision of care. The personal supervision policy, R414-45 cannot be applied to psychiatric services.

K. Organic Brain Disease is limited to treatment by the primary care provider. This diagnosis is not covered under the Prepaid Mental Health Plan.

L. Admission to a general hospital for psychiatric care by a physician requires prior authorization and is limited to those cases determined by established criteria and utilization review standards to be of a severity that appropriate intensity of service cannot be provided in any alternate setting.

M. Psychiatric evaluations are requested by the Department as part of the prior authorization process for patients who request specialty medical or surgical procedures. These procedures may be very traumatic, require long periods of recovery, require compliance with treatment regimens which may be limiting, challenging, and even necessitate some life style changes or adjustments in activity and life participation. These required psychiatric evaluations are limited to provision by a Board Certified or Board Eligible Psychiatrist with emphasis on the following:

Objective: To obtain a complete detailed or comprehensive psychiatric evaluation, provided in narrative form, by a Board Certified or Board Eligible Psychiatrist who is a Medicaid Provider.

Purposes:

- To determine stability of the individual – socially and emotionally.
- To determine the potential for compliance following surgery -- Medication, diet, lifestyle changes, follow-up.
- To identify support systems available to the individual.
- To assess ability of the individual to understand the procedure to be done and the consequences of the procedure.

The Health Care Financing Administration (HCFA) with considerable input from the American Psychiatric Association (APA) clarified and standardized elements necessary for patient examinations. The level of complexity of an evaluation determines the amount of reimbursement that can be expected. The levels of evaluation are consistent with other Evaluation and Management Codes and are 1) Problem Focused, requiring documentation of one to five elements; 2) Expanded Problem Focused, requiring documentation of at least six elements; 3) Detailed, requiring documentation of at least nine elements; and 4) Comprehensive requiring documentation of all elements.

The elements of a psychiatric examination as outlined by HCFA in cooperation with APA, include descriptions of the following:

- Speech: rate, volume, articulation, coherence, and spontaneity.
- Thought Process: rate of thoughts, content, (logical versus illogical), abstract reasoning and computation.
- Associations: (loose, tangential, circumstantial, intact).
- Abnormal or psychotic thoughts: (Including hallucinations, delusions, preoccupation with violence, homicidal or suicidal ideation, and obsession).
- Judgement: Concerning everyday activities and social activities.
- Insight: Concerning psychiatric status

Complete mental status examination including:

- Orientation to time, place, and person
- Recent and remote memory
- Attention span and concentration
- Language (naming objects, repeating phrases)
- Knowledge: awareness of current events, history, vocabulary
- Mood and Affect: depression, anxiety, agitation, hypomania, lability.

Other

Assess any other pertinent information which will help meet the objective and purpose of this requested evaluation including an understanding of the potential risks of surgery, realistic surgery expectations, and commitment of patient to comply with treatment which is crucial to weight loss success. Assess patient attitude and degree of determination/motivation to follow long term daily exercise and dietary regimen.

Billing

Detailed level evaluation: Use Consultation Code 99244
Comprehensive level evaluation: Use Comprehensive consultation Code 99245

*

N. Services to pregnant women who do not meet United States residency requirements (undocumented) are limited only to labor and delivery. No prenatal care or services can be covered with Medicaid funds. Refer to SECTION 1 of this manual, Chapter 13 - 8, Emergency Services Program For Non-Citizens.

The following criteria must be met for covering "Emergency Only Services":

- The condition manifests itself by sudden onset.
- The condition manifests itself by acute symptoms (including severe pain).
- The condition requires immediate medical attention.
  a. Immediate medical attention will require attention within 24 hours of the onset of symptoms or within 24 hours of diagnosis which ever comes earlier (no delay for scheduled or convenient time for service).
- The condition requires acute care, and is not chronic (Does no include any chemotherapy or follow-up care.
- Coverage will only be allowed until the condition is stabilized sufficient that the patient can leave the acute care facility, or no longer needs constant attention from a medical professional.
- The condition is not related to an organ transplant procedure.
- Prenatal or postpartum care are not covered.

Some selected conditions are representative of those in the prenatal period which meet the intent of the act, require "immediate medical attention", and if coded appropriately warrant payment without prior review. Records may still be subject to review if pulled in the mandated monthly sample or targeted for a focused review. The following codes are approved and will bypass prepayment review:

1. Diagnosis Code V22.2 - Pregnant state incidental, must appear on every claim as one of the diagnosis codes.

2. Abdominal Pain – Diagnosis codes 789.00 or 789.07.

3. Vaginal Bleeding – Diagnosis code 641.9

4. Threatened abortion – Diagnosis Code 640.03

5. Spontaneous abortion – Diagnosis 634.92
   Accommodation, without review, for complete spontaneous abortion was made some time ago for Medicaid clients. The appropriate related diagnosis and procedure codes must be on the claim for payment to be made without review.
   Note: An incomplete abortion which requires a D&C or vacuum extraction to complete must have medical record review, including operative and pathology reports, for approval before payment.

6. Missed abortion – (Fetal death without spontaneous abortion)
   Diagnosis code - 632 CPT codes for physicians - 59820 or 59821.
   Abortion will inevitably occur, but D&C or D&E may be indicated to prevent any maternal complications. Appropriate codes on the claim will facilitate payment without review.

7. Premature rupture of membranes – Diagnosis codes 658.11 or 658.13
   If delivery occurs within 24 hours of admission, no separate payment is warranted for the ruptured membrane services. Labor and Delivery codes only should be billed.

8. Threatened premature labor -- Diagnosis code 644.03
   (After 22 weeks but before 37 weeks gestation, without delivery). Depending on how premature and how advanced the labor is, it could lead to delivery or be treated to preserve the pregnancy for more development. However, any follow up or continuing care following the stabilization could not be covered.

9. Decreased fetal movement – Diagnosis code 655.73
   This could be an indication of symptoms which may or may not require emergency service. The evaluation should not require hospital service.

All other services to the undocumented population beyond those listed above, must still be edited and reviewed before payment.

Other codes which may be associated with the above services are listed below. Codes should be selected carefully based on the condition and the necessary services to stabilize the problem. Appropriate diagnosis to procedure edits must apply. All codes will not be appropriate for all complaints and may not be associated in the system editing and payment will be denied.
Physician office visit codes – 99201 - 99205
Physician Emergency Department visit codes - 99281 - 99285
Ultrasound CPT code - 76805 or 76815
Any CLIA approved CPT lab codes for physician office (Diagnosis to procedure edit must agree)
Fetal non-stress test – ICD.9 Procedure code 75.35 CPT Code 59025 (If done in a hospital must have the revenue code plus the CPT code.)
Fetal Monitor - 59050 - 59051

Special Limitations

- Routine prenatal care remains non-covered for this population
- Post Partum care only is also non-covered.
- Global codes should never be paid for service to this population. Edits in the system will only allow payment for codes 59409, 59514, 59612, or 59620.
- Abortion or early induced labor and delivery because of fetal anomalies, are non-covered services.

O. Seeking additional payment for services is limited to those cases where the circumstances are so unusual and severe that excess time is required to safely monitor and treat the patient. Documentation in the medical record must clearly show the extenuating circumstances and the unusual time commitment to warrant medical review and consideration of additional reimbursement.

P. Transfer of patients between physicians or between hospitals is limited to those circumstances where medically necessary, appropriate care cannot be provided by the physician or in the initial facility. Convenience or patient choice is not an adequate reason for transfers.

Q. Treatment of alcoholism or drug dependency in an inpatient setting is limited to acute care for detoxification only.

R. Abortion procedures are limited to those consistent with the Hyde Amendment restrictions. The Hyde amendment limits the use of federal funds for abortions to terminate a pregnancy under two conditions:

   A. resulting from an act of rape or incest; or

   B. In the case, with medical certification of necessity, where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed. (42 CFR 441.203 and Public Law Number 105-78 Section 509 and 510, pertaining to revisions of the Hyde Amendment, 1998).

   Refer to the instruction for Criteria #17 - Abortion in the attached Criteria For Medical And Surgical Procedures.

S. Mifepristone (Mifeprex or RU-486) for medical termination of pregnancy is available only when consistent with applicable Hyde Amendment restrictions. Refer to item R above.

   In addition to the criteria of item R above and Criteria #17 - Abortion (in the attached Criteria For Medical And Surgical Procedures), the following requirements must be met:

   1. The physician must have executed a Prescriber's Agreement with the pharmaceutical company. Mifepristone will be supplied only to licensed physicians who sign and return a Prescriber's Agreement with the pharmaceutical company. Distribution of Mifepristone will be subject to specific requirements imposed by the distributor. Mifepristone is a prescription drug, but it will not be available to the public through licensed pharmacies.

   2. Physicians must be able to provide surgical intervention in cases of incomplete abortion or severe bleeding, or have made plans to provide such care through others, and be able to assure patient access to medical facilities equipped to provide blood transfusions and resuscitation, if necessary.

   3. Pregnancy must be defined from history, clinical examination, or ultrasound, and must be confirmed at less than 49 days (7 weeks). For the purposes of this treatment, pregnancy is dated from the first day of the last menstrual period in a presumed 28 day cycle with ovulation occurring at mid-cycle. The physician must be able to assess the gestational age of an embryo and to diagnose ectopic pregnancies.

4. The physician must counsel and fully advise the patient of the treatment procedure and its effects. After discussion and being fully informed, the patient must reach the decision to terminate the pregnancy.

5. Physician must provide the patient with a copy of the Medication Guide. The FDA determined that a Medication Guide was necessary for women to be able to use Mifepristone effectively and safely. It is important for women to be fully informed about how Mifepristone works and about its risks, as well as the need for follow-up visits with the provider, especially the 14th day after administration of the medication(s).

6. The physician must provide an opportunity for the patient to get answers to any questions and resolve any concerns about the procedure. Each patient must understand the following:

    a. The necessity of completing the treatment schedule, including a follow-up visit at 14 days after taking mifepristone;

    b. That vaginal bleeding and uterine cramping probably will occur;

    c. that prolonged or heavy vaginal bleeding is not proof of a complete expulsion;

    d. that if a treatment fails, there is a risk of fetal malformation;

    e. that medical abortion treatment failures are managed by surgical termination; and

    f. the steps to take in an emergency situation, including precise instructions on whom to call and a telephone number for the patient to use if she has any problems or concerns during the treatment.

7. The physician must secure and witness the signature of the patient on the patient agreement form.

8. Prior authorization for the abortion procedure must be requested from Health Care Financing, Utilization Management Unit. A telephone request can be made with all essential documentation, copies of informed consent and patient agreement to be submitted in hard copy for review prior to authorization.

9. Medical termination of pregnancy with Mifepristone requires three office visits for the patient – day 1, day 3, and day 14, plus any emergencies that may arise during the period of the treatment.

10. Contraindications

    a. Use of Mifepristone is contraindicated in patients with any of the following:
        - Confirmed or suspected ectopic pregnancy or undiagnosed adnexal mass;
        - IUD in place;
        - Chronic adrenal failure;
        - Concurrent long-term corticosteroid therapy;
        - History of allergy to mifepristone, misoprostol, or other prostaglandin;
        - Hemorrhagic disorders or concurrent anticoagulation therapy;
        - Inherited porphyrias.

    b. Mifepristone should not be used by any patient who may be unable to understand the effects of the treatment procedure or to comply with its regimen.

T. Sterilization and hysterectomy procedures are limited to those which meet the requirements of 42 CFR 441 Subpart F. Refer to the instructions for Criteria #10, Sterilization / Other Genito-urinary Procedures, in the attached Criteria For Medical And Surgical Procedures.

U. Cosmetic, plastic, or reconstructive surgery is limited to medically necessary services which:
- Correct a congenital anomaly;
- Restore body form or function following an accidental injury; or
- Revise severe disfiguring and extensive scarring resulting from neoplastic surgery.

V. Removal of Benign or Premalignant Skin Lesions

Effective April 1, 2002, Medicaid will cover removal of skin lesions only when the procedure is medically necessary and meets the requirements of Criteria #34 on the list titled Criteria for Medical and Surgical Procedures. Removal of certain benign skin lesions that do not pose a threat to function or health are considered cosmetic and are not covered by Medicaid.

W. Trigger Point Injections

Effective April 1, 2002, Medicaid has new limitations on coverage of code 20552, injection; single or multiple trigger point(s), one or two muscle group(s), referred to as trigger point injections. Refer to Criteria #33 on the list titled Criteria for Medical and Surgical Procedures.

X. Exploratory laparotomy procedures confirm a diagnosis and determine the extent of necessary treatment. Payment for exploratory procedures is limited to those cases where the exploratory procedure is the only procedure performed during an operative session. When additional surgical procedures, identified and billed by separate identifiable procedure codes, are completed in addition to the laparotomy, reimbursement for the laparotomy will be denied. The additional procedures will be reimbursed in accordance with the multiple procedure methodology.

Y. Reserved for future use.

Z. Magnetic resonance imaging (MRI) is limited to coverage only for service to the brain, spinal cord, hip, thigh and abdomen. MRI of the spinal cord requires prior approval. Refer to Criteria For Medical And Surgical Procedures, Criteria#40B, Imaging.

AA. Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in R414-10A. (Kidney and cornea transplantations are an exception and do not require prior authorization.)

When an organ transplant procedure is done without authorization because the procedure does not meet the established criteria, payment will be denied for all services related to the transplant up to the outlier threshold days for the specific type of transplant. Medically necessary services beyond the initial denial period may be considered for payment.

BB. Hearing screens for infants are limited to those under the age of one year and in accordance with the nationally recommended strategy to have all infants receive a hearing screen. The recommendation is to have the screening completed as soon as possible after birth, while the infant is still hospitalized. Payment methodologies for this screening are limited by the type of service provider covering the child, e.g., HMO or fee for service.

CC. Vitamin B-12 is limited to use only in treating conditions where physiological mechanisms produce pernicious anemia.

DD. Vitamins may be provided only for:
- Pregnant women: Prenatal vitamins with 1 mg folic acid. [Prenatal vitamins are not covered post-delivery.]
- Children through age five: Children's vitamins with fluoride.
- Children through age one: Children's multiple vitamin (A C & D) without fluoride.
- Children through age 15: Fluoride supplement.

EE. Drugs and biologicals are limited to those approved by the Food and Drug Administration or the local Drug Utilization Review Board which has the authority to approve off label use of drugs.

FF. Human growth stimulating hormones are limited to CHEC eligible children under the age of 15 who meet the established criteria for coverage. Criteria are specified on the attached Drug Criteria and Limits List.

GG. Nonprescription, over-the-counter items are limited to those OTC drugs on the Over the Counter Drug List attached to this manual.

HH. Other limitations and pharmacy policy are available in the Utah Medicaid Provider Manual for Pharmacy Services, available on the Internet through a link on the Medicaid Provider's Guide http://health.utah.gov/medicaid/provhtml/provider.html, or contact Medicaid Information.

II. Injection administration codes 90471 and 90472 are new with the 1999 edition of the CPT Manual. These codes are limited to use with vaccine and toxoid codes 90476 through 90749. The existing limitation on other administration codes also applies to these codes: An office visit code and a vaccine or toxoid product code can be billed together, or the vaccine or toxoid product code and the administration code can be billed together, but all three codes cannot be billed for the same service on the same day.

The initial pneumovax vaccination is sufficient for most people. When revaccination is considered, they should be given at least 5 years apart to prevent adverse reactions. For updates on current adult vaccination recommendations and issues visit the CDC web site at http://www.cdc.gov/nip/recs/adult-schedule.pdf

JJ. Neonatal Care

Effective June 1, 1999 CPT code 99436, Attendance at Delivery, became available for use by board certified neonatologists and board certified pediatricians in urban or rural areas. Family practice physicians trained in neonatal care who practice in rural areas will be recognized and included for reimbursement.* This code can be used when a high risk delivery is expected, Neonatal Risk Factor Classification Levels three or four are met, and stabilization of the newborn is anticipated. The delivering physician must request the attendance of a qualified neonatologist, pediatrician or family practitioner at the high risk delivery. When resuscitation is required, CPT code 99440 would be used in place of 99436. The two codes cannot be used together.

* The American Academy of Pediatrics recognizes primary care pediatrician and neonatologist expertise in neonatal resuscitation and intubation. The American Academy of Family Practice Physicians and the American College of Obstetricians and Gynecologists have a joint policy statement which requires physicians attending delivery to maintain neonatal resuscitation skills.

Fetal/Neonatal Risk factors are outlined in Criteria #30 (Neonatal Care) in the Criteria For Medical And Surgical Procedures included with this manual.

Board certified neonatologists, board certified pediatricians, and family practice physicians practicing in rural areas are responsible for maintaining neonatal resuscitation skills.

Neonatal and Pediatric Critical Care Services are limited to those infants who meet the CPT definitions of critically ill and qualify for critical care services. The Neonatal and Pediatric Critical Care codes are designed to be global, covering a 24 hour period, and limited to billing only once each day per patient. The coverage and coding includes all physicians involved in care of the infant/child during the 24 hour period. Provision of Neonatal and Pediatric Critical Care Services is limited to Board Certified Neonatologists or Board Certified Pediatric intensivists.

Intensive (non-critical) low birth weight services provide for continuing intensive care of the very low birth weight or low birth weight infant, at or beyond 31 days of life, who no longer meets the definition of critically ill. Although no longer critically ill, the infant is still in need of Intensive Care with monitoring and constant observation by the health care team under direct physician supervision. Coding for Intensive, non-critical, very low birth weight or low birth weight services is by global 24 hour code requiring the same qualifications as those for critical care services. Services are bundled as outlined for the other neonatal and pediatric critical care services. Provision of non-critical services is limited to either a Board Certified Neonatologist, Board Certified Pediatric Intensivist, or a Board certified pediatrician.

KK. Neonatal Jaundice (Hyperbilirubinemia): Hospital Readmissions within 30 Days

Hyperbilirubinemia, or jaundice of the newborn, appears in a certain percentage of newborn infants within the first week of life. Symptoms vary from very mild to severe and life threatening. There is no way to predict which infants will develop symptoms of jaundice, and most infants are discharged from the hospital within a short time after birth.

According to the American Academy of Pediatrics, most healthy full term infants who develop jaundice may be safely managed as outpatients at home. However, the most severe cases require hospitalization. Since hyperbilirubinemia is not easily detected, and hospitalization may be necessary, readmissions with 30 days will be evaluated based on severity of illness and intensity of service, and a second DRG may be paid. Exception cases will be subject to random selection and review as part of the regular utilization management review process.

LL. Private Room Payment Requirements

Medicaid will pay for a private room when clinically indicated to prevent the spread of an infectious disease and in cases where the patient is colonized with a multi-drug-resistant organism which may present a serious risk of spread to other patients. Coverage will be based on current Centers for Disease Control and Prevention (CDC) guidelines.

A. Indications for Coverage

1. Payment for patient isolation in a negative pressure room will be limited to patients requiring isolation to prevent the spread of infectious disease through airborne droplets. This category includes patients with active infection with Mycobacterium Tuberculosis (pulmonary or laryngeal), Measles (Rubeola), Chickenpox (Varicella) or disseminated Shingles (Herpes Zoster in an immuno compromised patient).

2. Since the infectious respiratory droplets may be spread within a five foot radius of the patient, provision for a private room will be covered for those diseases transmitted by respiratory droplets. Infections in this category include meningitis, pneumonic plague, pharyngeal Diphtheria, Whooping Cough (Pertussis), Mycoplasma pneumonia, Small pox (Variola), Rubella (German Measles), or Mumps (Infectious parotitis).

3. Contact isolation for some infectious diseases is required until appropriate treatment has been provided or infectious period has passed. Diseases in this category include African hemorrhagic fevers (Marburg, Ebola, Lassa), cutaneous diphtheria, cutaneous tuberculosis, herpes zoster, bulbonic plaque, impetigo, and resolving viral infections in which infectious lesions are still present (Varicella, Variola). Diseases in this category which apply just to infants and young children include respiratory syncytial virus, adenovirus, parainfluenza viral infection, enteroviral infection, staphylococcal cutaneous infections and group A streptococcus.

4. Patients colonized with multi drug resistant organisms may not have a severe infection themselves but because of the nature of the organism may pose a threat to others. Patients infected or colonized with methicillin-resistant Staphyloccocus aureus (MRSA), Vancomycin-resistant enterococci, and multi-drug-resistant Streptococcus pneumoniae may be eligible for a private room. Documentation of drug resistance should be submitted. Cohorting or placing patients with the same infection into the same room should be done whenever feasible.

5. Infectious disease codes (ICD9) which qualify for a private room until the infectious stage wanes or antibiotic therapy is sufficient to ensure the patient is no longer infectious may be found in the provider and hospital sections of the Medicaid manual.

B. Limitations/Noncoverage

1. Neutropenic patient with a neutrophil count < 500 are more at risk for picking up serious life threatening infections. The Center for Disease Control states that these patients can be in a regular room if standard precautions are followed. Therefore, these patients are excluded from the private room policy.

2. A private room is no longer covered when the appropriate antibiotic therapy has been provided, making the patient no longer infectious. For those diseases with a known infectious period, a private room is no longer covered when the duration of infectiousness has passed.

C. ICD.9 Codes

Resistant organisms of concern must be listed with appropriate V code (V09.0-V09.91) :

041.04 Enterococcus or Streptococcus type D
041.11 Staphylococcus aureus
041.2 Streptococcus pneumoniae or pneumococcus

Other:

002.0 Typhoid fever listed with meningitis code 320.7
003.21 Salmonella meningitis
008.67 coxsackie virus and echovirus (enteroviral infection)
011.9 Pulmonary tuberculosis
012.3 Laryngeal tuberculosis
013.0 Tuberculosis meningitis
020.0 Bubonic plague
020.3, 020.4, 020.5 Pneumonic plague
027.0 Listerosis with meningitis code 320.7
032.1, 032.2, 032.3 nasal pharyngeal and laryngeal Diphtheria
033.0 Bordetella pertussis
033.9 Whooping cough with meningitis code 320.7
034.0 Group A streptococcus pharyngitis
036.0 Diplococcal, meningococcal meningitis
039.8 actinomycosis with meningitis code 320.7
047.0 Coxsackie virus related meningitis
047.1 Echo virus meningitis
047.8 other specified viral meningitis
047.9 unspecified viral meningitis
049.0 lymphocytic choriomeningitis virus
049.1 Meningitis related to adenovirus or enterovirus
050.0, 050.1, 050.2, 050.9 Small pox
052.0, 052.1, 052.7, 052.8, 052.9 Varicella or chickenpox
053.0 Herpes Zoster with meningitis
053.79 Herpes Zoster with other specified complication –-must specify in the medical record that infection is disseminated in immunocompromised patient.
054.72 Herpes simplex meningitis
055.9 Rubeola
056.9 Rubella
072.1 Mumps meningitis
072.0, 072.2, 072.3, 072.7, 072.71, 072.72, 072.79, 072.8, 072.9 Mumps
078.89 other unspecified disease due to virus Marburg, Lassa, Ebola
079.9 Respiratory syncytial virus
094.2 Syphilitic meningitis
112.83 Candidal meningitis
114.2 Coccidioidal meningitis
115.91 Histoplasmosis meningitis
320.0 Gram positive: Hemophilus meningitis
320.1 Pneumococcal meningitis
320.2 Streptococcal meningitis
320.3 Staphlococcal meningitis
320.7 Actinomycotic
320.81 Anaerobes: Bacteroides fragilis, Clostridium, peptostreptococcus, proprionbacterium, Treponema denticola, Treponema macrodenticum, Veillonella,.
320.82 Gram negative: Proteus morganii, Pseudomonas aeruginosa, Serratia marcescens, Vibrio vulnificus, Klebsiella pneumoniae, Escherichia coli, Aerobacter aerogenes
320.89 Meningitis due to specified bacteria: Bacillus pyocyaneus
320.9 Septic meningitis unspecified: bacterial, pyogenic, purulent, suppurative
321.0 Crytococcal meningitis with code 117.5
321.1 Meningitis from fungal disease with a code from range 110.0 to 118
321.2 Viral meningitis with a code from range 060.0 to 066.9
321.8 Nonbacterial organisms must include a code with the underlying disease
480.0 Adenoviral pneumoniae
480.1 Respiratory syncytial pneumonia
480.2 Parainfluenza
483.0 Mycoplasma pneumoniae
684 Inpetigo or Staphylococcal infection

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4 PRIOR AUTHORIZATION

When prior authorization is required for a health care service, the provider must obtain approval from Medicaid BEFORE service is rendered to the patient. Medicaid can pay for services only if ALL conditions of coverage have been met, including but not limited to, the requirement for prior authorization. Generally, a provider must complete a Request for Prior Authorization form and submit it with any required documentation to the Division of Health Care Financing, Utilization Management Unit. A copy of the form and instructions are included with this manual in the General Attachments section.

If a provider fails to obtain the required authorization, provides service anyway and then bills Medicaid, Medicaid must deny the claim. Because it was the provider's responsibility to obtain authorization, the provider is prohibited from subsequently billing the patient for the unpaid service.
[References: Utah Medicaid Provider Manual, SECTION 1, Chapter 6, Provider Enrollment and Compliance, and Chapter 9 - 7, Retroactive Authorization.]

Chapter 2, Covered Services, provides information as to services which require prior authorization. These services include, but are not limited to,

A. Drugs identified on the attached Drug Criteria and Limits List or in Medicaid Information Bulletins.

B. Medical supplies identified on the attached Medical Supplies List, in SECTION 2 of the Utah Medicaid Provider Manual for Medical Suppliers, or in Medicaid Information Bulletins.

C. Admission to a general hospital for psychiatric care by a physician.

D. Procedures and surgical services identified on the attached Medical and Surgical Procedures List or the Hospital Surgical Procedures List as requiring prior authorization.

E. Organ transplant services.

F. Any other service identified in a Medicaid Information Bulletin.

4 - 1 Retroactive Authorization

There are limited circumstances under which a provider may request authorization after service is rendered. These limitations are described in SECTION 1 of this manual, Chapter 9 - 7, Retroactive Authorization.

A. Complete a Request for Prior Authorization form according to instructions and provide justification for the request for retroactive authorization.

B. Include documentation from the medical record to support the emergent nature of the procedure. Send the documentation to the Division of Health Care Financing, Utilization Management Unit, for the prepayment review:

   For surgical procedures, documentation includes:

   1. Admission history and physical including any diagnostic testing confirming the diagnosis.

   2. Informed consent form for specified gynecological procedures (abortion, sterilization, hysterectomy) which clearly indicates the exact procedure to which the patient consented and information regarding the actual or potential loss of reproductive organ(s), reduction in ability to reproduce or permanent loss of ability to reproduce. Include evidence that the client understood the outcome(s) of the procedure(s) and received this information in writing. Also refer to criteria for abortion or hysterectomy in the attached Criteria For Medical And Surgical Procedures and to information for the abortion or hysterectomy consent forms included with this manual.

   3. Operative report

   4. Pathology report

   5. Discharge summary

5 NON-COVERED SERVICES

Certain services have been identified by agency staff and medical review to be noncovered for the Medicaid program because medical necessity, appropriateness, and cost effectiveness cannot be readily identified or justified for the purposes of medical assistance under Title XIX of the federal Social Security Act and Title 42 of the Code of Federal Regulations (CFR).

A. General Exclusions

a. Services rendered during a period the recipient was ineligible for Medicaid.

b. Services medically unnecessary or unreasonable.

c. Services which fail to meet existing standards of professional practice, which are currently professionally unacceptable, or which are investigational or experimental in nature.

d. Services requiring prior authorization, but for which such authorization was not requested, was not obtained, or was denied.

e. Services, elective in nature, and requested or provided only because of the recipient's personal preference.

f. Services for which third party payers are primarily responsible, e.g., Medicare, private health insurance, liability insurance. Medicaid may make a partial payment up to the Medicaid maximum if limit has not been reached by third party.

g. Services fraudulently claimed.

h. Services which represent abuse or overuse.

i. Services rejected or disallowed by Medicare when the rejection was based on any of the reasons set forth above.

j. When a procedure or service is not covered for any of the above reasons or because of specific policy exclusion, all related services and supplies, including institutional costs will be excluded for the standard post operative recovery period.

2. Specific, Non-Covered Services

   Medicaid does not cover the services specified below. Services not on this list are subject to the general exclusions in item A.

   a. Routine physical examinations for adults

   b. Experimental or medically unproven physician services or procedures.

   c. Cosmetic, reconstructive, or plastic surgery procedures which are elective or desired primarily for personal, psychological reasons or as a result of the aging process.

   d. Breast augmentation or reduction mammoplasty

   e. Panniculectomy and body sculpturing procedures

   f. Rhinoplasty unless there is evidence of a recent accidental injury resulting in significant obstruction of breathing

   g. Chemical peeling or dermabrasion of the face

   h. Revision of minor scars not related to major trauma

   i. Removal of tattoos

   j. Hair transplant

   k. Electrolysis

   l. Procedures related to transsexualism.

   m. Surgical procedures to implant prosthetic testicles or provide penile implants.

   n. Certain services are excluded as family planning services:

      (1) Surgical procedures for the reversal of previous elective sterilization, both male and female
      (2) Infertility studies
      (3) In-vitro fertilization
      (4) Artificial insemination
      (5) Surrogate motherhood, including all services, tests, and related charges
      (6) Abortion, except when the life of the mother would be endangered if the fetus were carried to term, or when pregnancy is the result of rape or incest

   o. Circumcision procedures for infants or adults, by clamp or surgical excision, are non-covered.

p. Certain services are excluded from coverage because medical necessity, appropriate utilization, and cost effectiveness of the service cannot be assured. A variety of lifestyle factors contribute to the "syndromes" associated with such services, and there is no specific therapy or treatment identified except for those that border on behavior modification, experimental or unproven practices. Services include:
   (1) Sleep apnea, or sleep studies, or both.
   (2) Pain clinics; and
   (3) Eating disorders clinics.

q. Finger/heel/ or ear sticks do not qualify for billing a specimen collection fee for an adult. Finger sticks used for blood reagent strip testing may not be billed as venipuncture.

r. Medications for appetite suppression (oral or injectable), surgical procedures, experimental therapies, or education/ nutritional/ support programs for treatment of obesity or weight control are excluded from coverage.

s. Office visits only for administration of medication are excluded from coverage.

t. A surgeon cannot provide general anesthesia in addition to providing the principle surgical procedure. Some regional or local anesthesia procedures don't require monitoring according to Medicare and may be completed by the surgeon. An example of this type of service is code 01995. Regional anesthesia provide by the surgeon is included within the global surgical fee and is not separately reimbursable. When monitoring is required during regional or local anesthesia, services are payable to the anesthesiologist.

u. The code 95920 – Intraoperative Neurophysiological testing by definition requires monitoring per hour of surgery. As per Medicare guidelines, the procedure is not covered for the surgeon, assistant surgeon, or anesthesiologist. The service is covered only when a separate physician provides the monitoring.

v. Standby or monitoring by the anesthesiologist or Nurse anesthetist during local anesthesia is not a covered Medicaid anesthesia service.

w. Treatment and evaluations of subluxation or flat feet. Treatment of flat foot is a condition in which one or more arches in the foot have flattened out. Surgical or nonsurgical treatments undertaken for the purpose of correcting a subluxated structure in the foot or devices directed toward care or correction of this condition, including prescription of supportive devices are not covered.

The Medical and Surgical Procedures List included with this manual provides a complete list of non-covered services identified by CPT code.

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